| Mental Health Medication Advisory Committee Meeting<br>Meeting Minutes, Open Session<br>August 8, 2017 at 2 pm – 4:30 pm | | |
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| **MHMAC**<br>Open Session<br>DXC Technology<br>Capital Room<br>6511 SE Forbes Ave,<br>Topeka, KS 66619 | **Committee Members Present:**<br>Susan Mosier, Secretary of KDHE, MD, MBA, FACS (Chair)<br>Vishal Adma, MD, MS, CMQ, CPE<br>Brad Grinage, MD<br>Rebecca Klingler, MD<br>Charles Millhuff, DO<br>Karen Moeller, PharmD, BCPP<br>Taylor Porter, MD<br><br>**Committee Members Absent:**<br>Holly Cobb, NP<br>Nicole Ellermeier, PharmD<br><br>**KDHE Staff Present:**<br>Ashley Goss, Deputy Secretary for Public Health, KDHE<br>Brad Kling, KDHE, Chief of Staff<br>Annette Grant, RPh, KDHE/DHCF<br>Robert Handke, PharmD, KDHE/DHCF<br>Carol Arace, KDHE/DHCF<br><br>**MCO Representatives Present:**<br>Jennifer Murff, RPh – United Healthcare<br>William Mack, MD – Amerigroup<br>Lisa Todd, RPh, BBA – Amerigroup<br>Angie Zhou, Pharm. D. – Sunflower<br>Katherine Friedebach, MD – Sunflower<br><br>**HP/HID Staff Present:**<br>Nancy Perry, RN<br>Karen Kluczykowski, RPh<br>Ariane Casey, Pharm. D. (phone) | **Representatives:**<br>Terry McGerry, Otsuka; Susan Zalenski, J&J; Amy Capball, KMHC; Conner Hampton, KDHE; Matt Keith, KDHE; Rick Keylan, Otsuka; Colin Thomasset, ACMHCK; Christina Giuffrida, FSGC |

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| I. Call to Order<br>A. Introductions<br><br>B. Announcements | **Call to Order:**<br>Dr. Mosier: I'm doing a test. Is this on? Can you hear me on the microphone? It is on? Ok. Yes. They can hear when I move. I just want to make sure people in the back can hear me so. Alright, well we will call the meeting to order.<br><br>**Introductions:**<br>Dr. Mosier: First, order of business is introductions; I do want to start with we have a new person at the table, Brad Kling is the Chief of Staff for our agency so I wanted to introduce him and then we'll go around from here and have Dr. Adma introduce yourself.<br><br>Dr. Adma: Do I use the microphone or?<br><br>Dr. Mosier: This is not probably… is this… is the reverb from this? Ok.<br><br>Dr. Adma: My name is Dr. Vishal Adma, I'm a psychiatrist practicing in Kansas City, Kansas. I am the Medical Director for KVC hospitals. I was the past president for the Kansas Psychiatric Society; I am here representing the Kansas Psychiatric Society.<br><br>Ms. Goss: I am Ashley Goss; I am the Deputy Secretary for Public Health at KDHE.<br><br>Dr. Mosier: I am Susan Mosier secretary of KDHE and I am the state health officer for Kansas.<br><br>Ms. Grant: I am Annette Grant; I am the Pharmacy Program Manager for KDHE.<br><br>Ms. Perry: Nancy Perry, Pharmacy review nurse here at DXC.<br><br>Dr. Handke: Robert Handke Assistant Pharmacy Program Manager at KDHE.<br><br>Ms. Arace: Carol Arace Division of Healthcare Finance, Administrative Assistant.<br><br>Dr. Friedebach: I am Katie Friedebach; I am the Chief Medical Director of Sunflower Health plan.<br><br>Dr. Mack: Bill Mack; I am the Behavioral Health Medical Director for Amerigroup. | Sec. Mosier called the August 8, 2017 MHMAC meeting to order at 2:08pm. |

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| | Dr. Moeller: I am Karen Moeller, a Psychiatric Pharmacist; I am with KU School of Pharmacy and I work with the adult psychiatry unit at KU Med.<br><br>Dr. Porter: Hi I'm Taylor Porter; I'm a psychiatrist. I work at Katie's Way in Manhattan and I'm still serving under approval from the mental health center Medical Director's Committee.<br><br>Dr. Klingler: I am Becky Klingler; I am a physician at Pediatric Associates in Manhattan.<br><br>Dr. Millhuff: Hi Chip Millhuff, child psychiatrist. I work here in Topeka at Family Service and Guidance Center.<br><br>Dr. Grinage: Hi, my name is Brad Grinage I am a psychiatrist for the National Center for PTSD and telepsychiatry through the VA but I also have a private forensic practice as well.<br><br>Dr. Murff: Hi I am Jennifer Murff and I am health plan Pharmacist for United Healthcare.<br><br>Dr. Todd: Hi my name is Lisa Todd and I am the Pharmacy Program Manager for Amerigroup.<br><br>Dr. Zhou: My name is Angie Zhou and I'm a Pharmacist for Sunflower Healthplan.<br><br>**Announcements:**<br><br>Dr. Mosier: Alright. Thank you all very much. And just a reminder that as we, as you see on the meeting agenda we have committee members here at the table, we also have KDHE staff and the MCO staff are here for assistance of the committee on information about operationalizing the criteria and other questions about data and information. So with that I'll move to old business. | |
| II. Old Business<br>A. Review and Approval of May 9, 2017 Meeting Minutes | **Committee Discussion:**<br>Dr. Mosier: We do not have meeting minutes for review and approval so we will get those out as soon as possible and go through those at the next meeting. | The minutes for the May 9, 2017 MHMAC meeting were not available for review at this time. Tabled to next meeting. |
| II. Old Business | **Clinical Public Comment: -** No requests were received. | Dr. Moeller made |

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| B. Prior Authorization Criteria<br>1. Use of Multiple Concurrent Mood Stabilizers | **Committee Discussion:**<br>Dr. Mosier: We do have minutes though in the packet; some information that you will see was from the prior discussion on multiple concurrent mood stabilizers so as we move to that criteria one of the requests of the committee was to have additional data and that's on this particular sheet and it shows four tables; one that is for taken concurrently for greater than 60 days, the 31 to 60 days, the one to 30 days and then the totals and they're looking at without Topiramate, with Topiramate. And I can't pronounce that Q-s-y-m-i-a.<br><br>Dr. Porter: They really went to town on that one.<br><br>[Unknown]: Qsymia.<br><br>Dr. Mosier: Qsymia? Doesn't a Q have to have a u after it?<br><br>Dr. Todd: Unless it's a drug.<br><br>Dr. Mosier: Unless it's a drug; got it. So you can review this, but basically there's three options on the table and I want to remind people on the, we do also have it is a very short sheet for the use of multiple concurrent mood stabilizers has some information there. But, while we were asked to look at every drug class we are not required to have prior authorization or criteria on every drug class. So option one in this drug class is that we decide that that no criteria are needed. A second option; there was a long set of discussion around whether or not using three or more as the, as the criteria and the discussion of with or without topiramate because of the multiple uses of topiramate so I would say and there's also discussion around four or more. So a second option would be four or more based upon the criteria here with topiramate and then a third option would be three or more without topiramate and Qsymia or topiramate products however you would want to phrase that. So I really put those out as the three options on the table for discussion and ask for your input and feedback on that.<br><br>Dr. Grinage: Just a point of clarification so does this include and, forgive me because I wasn't here back in the November timeframe, but does this include atypicals as mood stabilizers or not? No, this is only… | the motion to change 'Three or more different mood stabilizers used concurrently for greater than 60 days will require a prior authorization:' to 'Four or more different mood stabilizers used concurrently for greater than 60 days will require a prior authorization:'<br><br>Dr. Porter Seconded the motion.<br><br>The motion carried unanimously. |

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| | Dr. Adma: This is typical, lithium.<br><br>Dr. Grinage: Ok so it's defined as a traditional mood stabilizers?<br><br>Dr. Adma: Yes.<br><br>Dr. Grinage: And the second thing is on this list, where it says three or more with topiramate is that topiramate one of the three or more or does that really mean it is three or more plus topiramate? Or three or more with topiramate and phentermine?<br><br>Dr. Mosier: It's included in the… When it says with it's included in the count.<br><br>Dr. Grinage: It's included so those three when you look at three or more with topiramate one of the three is topiramate and the same way with the two in the last column with topiramate or phentermine. Those are included in the count.<br><br>Dr. Mosier: Yes.<br><br>Dr. Grinage: Ok thank you.<br><br>Dr. Moeller: Just for clarification does it exclude people with seizure disorders?<br><br>Dr. Adma: That's a good question.<br><br>Dr. Moeller: I mean, I don't… these are old medications. These aren't the newest seizure medications but if someone had a seizure disorder…<br><br>Dr. Adma: Concurrent seizure disorder. That's a good question.<br><br>Dr. Moeller: So…<br><br>Dr. Adma: Do you have anything to say?<br><br>Dr. Porter: I'm sorry it does exclude them or it does not? | |

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| | Dr. Handke: The data does not no. They were on multiple ones they were counted.<br><br>Dr. Porter: Regardless of diagnosis?<br><br>Dr. Handke: Yes.<br><br>Dr. Porter: Thank you.<br><br>Dr. Moeller: I would propose no criteria or four or more to be the option.<br><br>Dr Adma: I think it's pretty common that our patients could be on Depakote, Lithium and topiramate and that's clinically, that's reasonable to use that combination. Topiramate probably its being used to counteract the weight gain or something like that. Yeah. So I agree with that thought.<br><br>Dr. Moeller: Does anyone have a specific that you think we need?<br><br>Dr. Adma: Data indicates that you know at the 60 day mark it's a very small number of them of three or more when you combine even without topiramate right? Only eleven patients throughout the state of Kansas who are on the MCO plan so it's a very, very small number.<br><br>Dr. Moeller: I, at looking at this you know with four or more as being only one or twos or threes there's no point in having more room for error. So I propose no, no prior auth on stabilizers.<br><br>Dr. Millhuff: So I'm just going to speak up in respect to safety in kids and I can't think of any patient that I have that would be on more than three of these at once. We have a lot of kids that are, you know, seeing the pediatric neurologist for various kinds of conditions and I will also reference these Texas guidelines which they, they'll trigger a review for mood stabilizers if you are on three or more but that's their, that's a focus on pediatrics. So I'm fine with not having anything here. It doesn't seem, we don't have any age sensitive data here do we; I don't see that.<br><br>Dr. Handke: Sorry on the ones that have Topiramate or Qsymia®, I did check the patients on those. There was only one who was 18 and the rest of them were all are in their 30's. | |

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| | Dr. Millhuff: Ok, so it's it would be…<br><br>Dr. Handke: I only did it on just the ones without the Topiramate on three or more.<br><br>Dr. Millhuff: Great, ok.<br><br>Dr. Adma: Which is a good sign so at least…<br><br>Dr. Millhuff: Exactly so it doesn't look like it's as much of a concern with prescribers.<br><br>Dr. Porter: Yeah. We have, we have not a real big problem with this in the state currently. So the question is have any or at least put one out there, I think that it has been proposed, to give people kind of a reminder to not have people, kind of, I guess, a gutter ball guard in place. Don't do that because it really is uncommon. I think it could make sense to put something, like what you said, to put it four or more triggers review. Even though it looks like it's not really needed because there's one that did it for more than 60 days.<br><br>Dr. Mosier: So let's do one other thing and then we can have a motion on the table, I think. Why don't you just review the rest of the criteria; I think you had that up earlier I'm just going through so, everybody's familiar with that.<br><br>Ms. Grant: Ok. So the following drugs require prior authorization will be any Carbamazepine, any Lamotrigine, any Lithium, any Oxcarbazepine, any Topiramate or any Valproic Acid. Noting that Topiramate could be a combination of Qsymia which has Phentermine in it. The proposed criteria would be three or more different mood stabilizers used concurrently for greater than 60 days will require prior authorization. At least one medication must be prescribed by or in consultation with collaboration with a neurologist. The patient must have a documented seizure related diagnosis within the previous 365 days.<br><br>Dr. Mosier: So there's a proposal to change that to four. Are there, is the remainder of the criteria…<br><br>Dr. Grinage: Well that's a little concerning to me that a patient must have a documented seizure related diagnosis because we use the mood stabilizers for pain, for a lot of different reasons than | |

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| | mood stabilization so but, I guess, I agree with the four is a little bit much and I don't really want to leave that in there four or not I'm just kind of throwing that out, but, severe cases you might have someone on four medications. It's going to be highly unlikely, but without it, I just don't know what other providers think.<br><br>Dr. Mosier: Are you proposing removing the second criteria there?<br><br>Dr. Adma: If you change that to four or more.<br><br>Dr. Grinage: I would feel more comfortable yeah.<br><br>Dr. Adma: Yeah then everything else would fall.<br><br>Dr. Mosier: Then everything else remains?<br><br>Dr. Grinage: Yes.<br><br>Dr. Mosier: Ok.<br><br>Dr. Porter: I guess a protocol question if you have the second bullet point; let's say you were one of these people that were, and left at three, you were one of the people that were on three and you were on Lithium, Lamictal®, and then Topiramate for your migraines so, no seizure disorder then would your review be denied if you were… Let's say you didn't get the managed care review it would then be declined because they didn't have a seizure disorder? If we kept the bullets like this?<br><br>Dr. Mosier: Require review.<br><br>Dr. Murff: It would certainly require review and I think it would be at risk for doing that.<br><br>Dr. Porter: Because if you…<br><br>Dr. Murff: If you look at that as a…<br><br>Dr. Porter: If you're a reviewer, you look right there and go no seizure disorder, doesn't meet | |

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| | criteria.<br><br>Dr. Murff: So I think…<br><br>Dr. Porter: Ok thank you. I think it needs to be four and remove the second bullet would be my, my thought about it.<br><br>Dr. Grinage: I would agree with four and I have a question if Gabapentin is included in this?<br><br>Dr. Handke: No.<br><br>Dr. Mosier: So is there a proposal on the table to keep these criteria with the single change from three to four? Is that the proposal? Ok, may I have a motion for that?<br><br>Dr. Moeller: I'll motion to change the 'three' to 'four'.<br><br>Dr. Porter: Second.<br><br>Dr. Mosier: All in favor?<br><br>{Several 'Ayes' are heard}<br><br>Dr. Mosier: Any opposed-'Nay'?<br><br>{Silence}<br><br>Ms. Arace: Did we have a second?<br><br>Dr. Mosier: Yes we did have a second.<br><br>Ms. Arace: Thank you.<br><br>Dr. Mosier: For moved and seconded. Ok. | |

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| | Dr. Adma: And what does the group think about taking away the seizure diagnosis because there could be others?<br><br>Dr. Porter: My thought was if you make it four you could leave that on there and I think I probably get closer to needing, it's harder to explain, four under any case and a seizure would make a step in that direction I guess.<br><br>Dr. Grinage: I guess if you have a neurologist involved there may be other reasons why but if nothing else it would trigger, I'm ok with that.<br><br>Dr. Millhuff: Would a neurologist be gold carded on these criteria? A board certified neurologist?<br><br>Ms. Grant: I don't think we would need that, I mean this situation would come up so rare that I don't, I don't think we need to even go down that road.<br><br>Dr. Millhuff: Ok.<br><br>Dr. Mosier: Anything else? | |
| III. New Business<br>A. Prior Authorization<br>1. Benzodiazepine Dosing Limits | **Clinical Public Comment: -** No requests were received.<br><br>**Committee Discussion:**<br>Dr. Mosier: Ok we have one order of new business for criteria that's on the benzodiazepine dosing limits, so if we can pull that up. Oral, Adult Oral Benzodiazepine dosing limits.<br><br>Ms. Grant: Okay, so Adult Oral Benzodiazepine dosing limits the following drugs Alprazolam, Chlordiazepoxide, Clobazam, Clonazepam, Clorazepate, Diazepam, Estazoloam, Flurazepam, Lorazepam, Oxazepam, Quazepam, Temazepam, Triazolam doses exceeding those listed in the table below will require prior authorization. Prior authorization will require written and/or peer-to-peer review with the health plan psychiatrist, medical director, and/or pharmacy director for approval. The doses in the tables below are the maximums from Facts and Comparisons. Total maximum not by diagnosis. It's just the max for any indication dose. So for instance Clonazepam you wouldn't use 20mg for anxiety but you would do that for seizures; so that type of thing. It's the max regardless of the indication. I figured that was just a good starting point. I know there are clinical differences between how you might practice sometimes you use literature review versus | New Business first time Discussion. |

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| | Facts and Comparisons but that's where I'm looking for you today to tell me if a dose should be different than what's on here.<br><br>Dr. Grinage: So this is FDA approval; approved doses by FDA?<br><br>Ms. Grant: According to Facts and Comparisons, yes.<br><br>Dr. Grinage: My thinking, I may be wrong it has been a while since I looked at them. The Lorazepam I thought was 12mg.<br><br>Ms. Grant: I just went by what the Facts and Comparisons reference said.<br><br>Dr. Grinage: Ok.<br><br>Ms. Grant: I think a couple actually did say there was no well-established maximum doses but the standard max is where the 10mg came from. So that's again is where your clinical practice will dictate what you think the maximum should be.<br><br>Dr. Grinage: The only reason I ask is because one rare case in my residency required 12mg. But I would think that would want to be looked at anyway so.<br><br>Dr. Moeller: That probably was inpatient, right?<br><br>Dr. Grinage: Yes it was, absolutely.<br><br>Dr. Adma: And where did you get these numbers from?<br><br>Ms. Grant: Facts and Comparison reference; it's the, that and clinical pharmacology are the two most common references that are used. In the field of pharmacy anyway.<br><br>Dr. Porter: I note that Alprazolam is considered a more potent milligram than lorazepam and that's the same maximum, they have the same maximum dose.<br><br>Dr. Adma: And in my practice I use a lot smaller doses than this; much smaller so again. | |

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| | Dr. Moeller: These are very high.<br><br>Dr. Adma: These are really, really high doses.<br><br>Dr. Moeller: In the olden day's that is what they used.<br><br>Dr. Adma: Yeah. I mean the question is when you talk about safety if you put these limits that high, I don't know if, have you looked at data, I mean are people prescribing higher doses than this?<br><br>Ms. Grant: That's what I'm saying, I just bring you the…<br><br>Dr. Porter: to start.<br><br>Ms. Grant: …the guidelines to start with and that's where your clinical expertise would say this is what we think.<br><br>Dr. Adma: Do you have any data on some of this stuff? What is the average doses of these medications that clinicians in Kansas are prescribing?<br><br>Dr. Zhou: Unfortunately we did not pull data, we weren't asked.<br><br>Ms. Grant: I didn't ask them because I just went with the reference guide and for the.<br><br>Dr. Porter: It's straight forward in a way but somebody mentioned Clonazepam is actually indicated for seizures.<br><br>Ms. Grant: Right, that's why it has a higher dose than you would use it for anxiety.<br><br>Dr. Porter: Which is, but it's also one of the main one's used in mental health. And in some ways this is somebody across the state in mental health centers and other places there's people sitting down with potential patients who, and having sort of a tug of war over this particular group of medicines, and I can't help but have, have the thought that it's one gift would be lower amounts. It | |

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| | may cut some people off, medical treatment would be the trade. The problem would be there might be people that require that but if you are sitting in the office and KanCare doesn't cover above a lower number than what these are then it would short change that discussion and an argument that you might even be in with somebody who thinks they need a higher dose of it. Higher doses of these, as we know, do have health risks with them, especially they make depression worse, memory, balance, driving, you know, a number of reasons why these higher doses that are on here might be just what one person needs but overall are high.<br><br>Dr. Grinage: And I would, I would include probably what's just as important to look at, as DEA has been looking at, is in combination with the opioids. Death rate with opioid/benzo combination. And I don't believe Kansas at this time requires PDMP. I mean, are we, does Kansas require, I know other states that I am now practicing in I have to go in and look at the state registry but I think Kansas has it available but it is not required at this time.<br><br>Ms. Grant: Our long acting opioid policy does require that they go and check the K-TRACS site. But as, other than that, no, not for short acting.<br><br>Dr. Grinage: Not for short acting<br><br>Ms. Grant: But we are, that is a topic we are gathering data and discussing now.<br><br>Dr. Grinage: In Pennsylvania every prescription of Benzodiazepine has to be queried. Every one. But they have a pretty high death rate by suicide opioid, or by opioid and Benzo combo.<br><br>Dr. Adma: So now that we have this in front of us do we say instead of just approving this do we say, can we look at the data and then make a reasonable decision as to if we need to lower the dose and see what that would look like?<br><br>Dr. Mosier: And I will point out that this is on new business and just kind of a point of order on how we; when it's on new business today is a day of discussion and today we won't vote on this until at least the next time so that you are satisfied and we can bring data etc. so the answer to the question is, yes.<br><br>Dr Adma: That's easy. | |

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| | Dr. Grinage: And it might get complicated but you might want to consider maybe that's, not our job here, but consider two separate scenarios just with Benzos alone versus Benzos and an opioid.<br><br>Dr. Adma: Yeah.<br><br>Dr. Grinage: I mean short or long acting I think that's a big topic.<br><br>Dr. Porter: And in a way the other way with the opioid policy, prohibits benzos that we've approved. Right?<br><br>Dr. Grinage: The opioid policy?<br><br>Dr. Porter: Suboxone® actually wasn't on it. That was just Suboxone®.<br><br>Dr. Grinage: Yeah, I don't think we've done the queue. Even Tramadol.<br><br>Dr. Porter: You're right.<br><br>Dr. Mosier: So in terms of the data that you would like to look at. You had mentioned one earlier about of looking at maybe that general max dose that you see prescribed in the program.<br><br>Dr. Adma: Yeah on each of these.<br><br>Dr. Mosier: And this specifically is an adult, an adult group so we'll look at look at the age range. We can bring data you know as we look at other age ranges too so if you would like we can go ahead and pull that data as well.<br><br>Dr. Porter: One thing that might be good if are able to mine data that would be we could take these that seem like high but medically approved doses but also and see how many people are above that; that would be one thing, but also how many are above half of this dose. Would be an area that would probably already in the red zone of most of our prescriptions, prescribing practices.<br><br>Dr. Adma: Can we go by this list and indicate what we feel based on our clinical practice; say what | |

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| | should be maybe you know for Xanax®; is it 6mg?<br><br>Dr. Moeller: That's what I was thinking.<br><br>Dr. Adma: And then anything above 6mg we need to know what percentage of them are over 6mg. Or something like that and that gives them an idea. That might be our threshold or something like that.<br><br>Dr. Moeller: Because like Chlordiazepoxide I mean 300mg inpatient, for alcohol, right? I don't know what it would be outpatient.<br><br>Dr. Adma: Yeah.<br><br>Dr. Grinage: I don't know that too many people use it if they're outpatient.<br><br>Dr. Moeller: What did you say?<br><br>Dr. Grinage: I don't think too many people use it for outpatient.<br><br>Dr. Moeller: I don't think that there are several on here are I just don't think. Now Clobazam isn't that mainly only used only for seizures?<br><br>Dr. Porter: I don't know what that is.<br><br>Dr. Klingler: It is being used more and more in pediatric seizures.<br><br>Dr. Moller: For seizures.<br><br>Dr. Klingler: Yeah.<br><br>Dr. Moeller: I'm sure that is probably in accordance with the dosing.<br><br>Dr. Adma: What do you think… what do you think the upper limit of that, Dr. Klingler on that, we don't use that much you know? | |

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| | Dr. Klinger: I wouldn't know what the upper limit is, sorry.<br><br>Dr. Adma: Ok.<br><br>Dr. Porter: It is really interesting Temazepam is at its recommended dose, you know, dose is 30.<br><br>Dr. Moeller: And Triazolam too, right? 0.5mg?<br><br>Dr. Adma: I don't use that much so I don't know.<br><br>Dr. Porter: Halcion®, is that Halcion® is it… Halcion®?<br><br>Dr. Moeller: Halcion®, yeah.<br><br>Dr. Millhuff: How do these numbers compare to other states in our area?<br><br>Ms. Grant: I didn't look. Would you like us to look?<br><br>Dr. Millhuff: Might, might be useful to know if there's other more established guidelines on this.<br><br>Dr. Moeller: I guess we could look at it I mean because some of these are just so old that none of us really are familiar with them. I mean we can all look at like Diazepam I mean I still see that. Would you say 30, I would be curious how many is above 30mg is what I would put. I mean I do see people come in on 10 three times a day. I see that pretty frequently, so.<br><br>Dr. Adma: 40 is not that bad, too.<br><br>D. Moeller: I was going to say 40 maybe that's fine.<br><br>Dr. Porter: It's really a scatter about what's kind of closer to where you use it and what seems really high.<br><br>Dr. Moeller: I think the Alprazolam and same as the Clonazepam, I mean seeing that greater than 6 | |

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| | or 8.<br><br>Dr. Adma: So do we pick 8mg for Clonazepam?<br><br>Dr. Moeller: 8mg would be.<br><br>Ms. Grant: On Clonazepam?<br><br>Dr. Adma: Yes.<br><br>Dr. Moeller: Clonazepam.<br><br>Ms. Grant: But if you use up to 20mg in seizure would you want to limit it to that though? So we kind of want the max regardless of any indication would be my…<br><br>Dr. Mosier: Well I think it's up to you guys what max you want to set.<br><br>Ms. Grant: So if we edit for someone who has seizures that would?<br><br>Dr. Grinage: We wouldn't be prescribing. That would probably be prescribed by the neurologist not the mental health.<br><br>Dr. Adma: Would that be linked to their NPI? Like a neurologist prescribing, would the MCO's know well this is not a psychiatrist it's a neurologist or not?<br><br>Dr. Zhou: I would say operationally that would be tough.<br><br>Dr. Adma: Okay.<br><br>Dr. Grinage: Because if it's for seizures disorder, usually it's going to be the neurologist that prescribes it.<br><br>Dr. Adma: Right. | |

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| | Dr. Porter: So what we want to do is go ahead and find out how common prescriptions higher than certain numbers are in the state and we can start with these here but we would also on at least a couple of them look at like a lower, what seems to us more reasonable clinical number. 6 of Alprazolam; 8 of Clonazepam, at least in psychiatry. Should those be the same? Should, just throw that out… those are pretty equal potent medicines should they have the same? Should we look at the same dose of them?<br><br>Dr. Adma: The Lorazepam?<br><br>Dr. Porter: And Clonazepam.<br><br>Dr. Moeller: I was just going; procedures.<br><br>Dr. Adma: It's actually; actually, I thought the Lorazepam is even more potent than Clonazepam, right?<br><br>Dr. Grinage: Yeah, for psychiatry it's only 4 or 5mg. But I have seen people up to 8mg with Clonazepam but higher reasonably.<br><br>Dr. Moeller: That's what I thought with Clonazepam.<br><br>Dr. Porter: Okay.<br><br>Dr. Moeller: I mean yeah we use really low doses; 6 would be high but I would say 8 for Clonazepam. She keeps going back and forth.<br><br>Dr. Adma: Do we put 8mg for Lorazepam too at the higher end then; or 6?<br><br>Dr. Porter: What we are trying to do is see how many people are higher than a certain number in the state.<br><br>Dr. Adma: Yeah.<br><br>Dr. Moeller: I'd say 6 but I'm fine with 8. Whatever. | |

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| | Male: Okay.<br><br>Dr. Moeller: What do some of the other psychiatrists think?<br><br>Dr. Porter: Chip you're not into this?<br><br>Dr. Grinage: I spend my time taking people off of these medications.<br><br>Dr. Moeller: I know.<br><br>Male: And it's a lot harder to take people off.<br><br>Dr. Moeller: I think the problem is, we try not to use any of these. So 6 is, two TID, is usually the highest.<br><br>Dr. Grinage: I think Alprazolam, Flurazepam, Diazepam, Lorazepam, and Temazepam, are probably the one's I most often see. Like the Serax® is used mostly inpatient and the Librium® is used in the inpatient. These others one's I don't really see much of them used, unless it's in…<br><br>Dr. Moeller: I hope we don't see a Flurazepam.<br><br>Dr. Grinage: I've seen Tranxene®. I had to look that one up.<br><br>Dr. Moeller: Yeah. That's Clorazepate; I have seen that one but it's always been for seizure disorders. I thought that was…<br><br>Dr. Porter: Do you want… do you want to propose some lower numbers to look at in addition to these?<br><br>Dr. Moeller: I don't know at this time.<br><br>Dr. Porter: Okay, I'll put a motion up. I'll move that we take, that we look at these numbers which are the maximum and then we also look at for Alprazolam- 6mg; for Clonazepam-8mg; for | |

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| | Diazepam-leave it alone, and for Lorazepam, also 6mg.<br><br>Dr. Grinage: For Lorazepam?<br><br>Dr. Porter: Yeah, actually, I'll put up my proposal and then you guys change it. I'd go 6 on Alprazolam and I'd go 8 on Clonazepam; I'd go 8 on Lorazepam and those would be the changes I would… That would be a little bit lower level to fish at to see how many people are over those numbers.<br><br>Dr. Grinage: I don't know that we need a motion, right? This is just to let them know what data you want. So, if you could look at the maximum and then maybe take these, these more clinically, psychiatrically clinically appropriate doses of these medications and give us some idea of how many people may be above that. Could we do that?<br><br>Dr. Adma: Is there a way for us to get some opinion from a neurologist on these dose? Because this could be psychiatry and all neurology, right? So maybe some; I don't know how we can get that at least some input from a neurologist to comment on this, for the committee can look at it.<br><br>Dr. Porter: Does DUR have a neurologist or access to a neurologist?<br><br>Dr. Mosier: We can find access to a neurologist. I don't believe that we have a neurologist on DUR currently. But we will, we will find that information.<br><br>Dr. Grinage: So, the pharmacy, they don't care who writes it, this is the guidelines, the parameters, right? If they see it coming from a neurologist they're not looking at a different criteria for authorization? Are they or are they not? No.<br><br>Male: They don't know, operationally it is going to be different.<br><br>Dr. Mosier: It's…<br><br>Dr. Grinage: I think it behooves us to make a neurology call.<br><br>Dr. Porter: Is it; is it possible; how difficult it would be data mining, especially on the Clonazepam, | |

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| | if we get the ones that are above the 8, determine how many have a seizure disorder. Is that something that can be pulled up reasonably easily?<br><br>Dr. Handke: I'm not sure I can do that. No, I'm not sure if they can do that or not.<br><br>Ms. Grant: A lot of times…<br><br>Dr. Handke: I would have to research that whether or not.<br><br>Dr. Zhou: Maybe, it depends, it may be easier to determine if it was prescribed by a neurologist in that instance that.<br><br>Dr. Porter: Okay.<br><br>Dr. Zhou: Because you can look at the NPI and look at NPI registry we can always assist with that as well.<br><br>Dr. Porter: Okay.<br><br>Dr. Moeller: I have a question on this proposal. Is this dosing limits? Do we ever want are we ever going to do anything like two or more?<br><br>Ms. Grant: We already have that.<br><br>Dr. Moeller: Okay, good.<br><br>Dr. Grinage: Could I maybe even suggest, I don't know if we are getting to complex, but it would be nice to see how much Benzos is prescribed with concomitant opioid use. Is that a possible add piece that we could get? Numbers on Benzos or specific Benzos used with opioid use.<br><br>Dr. Moeller: I think that is a very important thing to look at.<br><br>Dr. Porter: I think unfortunately a lot of those overdoses are not prescribed overdoses, but still nothing wrong with looking at it. | |

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| | Ms. Grant: On the adult part is it going to be 16 and older or 18 older? What would we consider for age group, considered an adult, on this one?<br><br>Dr. Millhuff: 18.<br><br>Dr. Klingler: 18.<br><br>Ms. Grant: Would that just be for data or also for the title?<br><br>Dr. Millhuff: For the data right now. Do we have sense of how many pediatric patients are taking these kinds of meds?<br><br>Dr. Porter: Well if we cut this off at 18 we won't.<br><br>Dr. Millhuff: Right.<br><br>Dr. Porter: If we mined it a little lower you might find that out.<br><br>Dr. Millhuff: What she was asking about was the data collection versus the policy.<br><br>Dr. Mosier: I think for the policy it would be defined as 18 year old. The data we will get going with the policy and then whatever other groupings that you want to look at. If you just want to look at less than 18 or if you want to group it out the same way that we have grouped out the other policies what we have looked at I think it was under 4, 4 to 6, and so you want to look at those groupings just to make sure that there's not.<br><br>Dr. Millhuff: In the data?<br><br>Dr. Mosier: Yeah.<br><br>Dr. Millhuff: Sure.<br><br>Dr. Klingler: And when you mine the data is it possible to look at psychiatry, neurology and other? | |

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| | Because I think that would be the other thing is how many of these prescriptions are coming from somebody other than neurology or psychiatry.<br><br>Dr. Mosier: Yeah.<br><br>Dr. Moeller: It would be interesting to see if high doses were from non-psychiatry. Or, that's where I usually see most people, even dentists.<br><br>Dr. Porter: Okay.<br><br>Dr. Moeller: Seriously I mean a dentist prescribe a valium prescription.<br><br>Dr. Porter: I realize we're asking for a lot of data but this is really, probably one of the more complicated pharmacologic areas in our field between helping people and harming people and etc. etc. I appreciate all the taking all the extra data hits from us.<br><br>Dr. Mosier: That's why we meet quarterly; we've got three months to get it pulled.<br><br>Dr. Klingler: Well and I'd like to see the non-neurology, non-psychiatric usage too because I probably get a request for one of these drugs in my office once a week. Which are all denied, but it's amazing how many people would like their kids sedated with a Benzo. So, yeah, we don't prescribe these from our office other than some very specific diagnoses so. I think there is some pressure on primary care to give these out both in pediatrics and adults.<br><br>Dr. Millhuff: I'm curious if you're seeing a pattern with a prescriber that, from the managed care organization standpoint, that you are seeing a lot of Benzos prescribed for a pediatric patient. Does this trigger some kind of red flag or review automatically?<br><br>Dr. Friedebach: I know it does in antipsychotics. I'll have to look to see. We've got the PMUR program that looks at prescribing patterns and I'm not certain if they look at Benzos or not, honestly, so I will have to follow-up on that.<br><br>Dr. Millhuff: Can you comment a little bit more about that PMUR process? | |

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| | Dr. Friedebach: Yeah we have had that in place since the beginning of Sunflower we are looking for specific prescribing patterns. A lot of our focus has been around antipsychotic use. And when we see a specific pattern come through whether that's by an increase in dose or multiple concurrent prescribing, then we have a group that gets together all the clinical available; clinical information that's available. We have a psychiatrist that actually reviews that and then they categorize those cases based on what they find in that review. If they find that it is clinically substantiated; appears to be appropriate; then that doesn't go any further. If the psychiatrist sees that that's not, the prescribing is not substantiated with the standard of care with the clinical we have available then they outreach for one on one conversation with the psychiatrist. Sometimes that might be with a nurse practitioner, sometimes it may be a primary care provider, but it's a professional to professional discussion around that specific individual's care. And then they follow-up on regular intervals to look and see has that behavior been modified or not and if the potential for them to outreach again and say hey we kind of discussed a plan of attack on this; and there are some patients that after that discussion they see well there were extenuating circumstances, we didn't get all the clinical documentation but it's ok and then they move into that other category where we've determined that it is not a concern. But, for that group that it is a concern we've discussed for the need to modify their treatment there is a follow-up in that. One of the things that we've found traditionally is, it's kind of tough, because that provider may have very strong feelings why they're strategy in that member is very well validated and may not take the perspective of our expert for something that has to prompt change. And so it's one of the things that, at least from our perspective, has been supportive of the process that you have in place because we've had the PMUR program going on throughout KanCare so I think if you have a very receptive provider then that approach is going to be very affective but for the group you are trying to target it may not be, because they might not really agree with that assertion.<br><br>Male: Is that just applied for kids?<br><br>Dr. Friedebach: It is. I think that we may have expanded it to our waiver population.<br><br>Dr. Zhou: Yeah, so we have I/DD, foster care, and SSI and then I can't remember if there is another population as well.<br><br>Dr. Friedebach: I think that's it. | |

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| | Dr. Zhou: So that covers a broad range.<br><br>Dr. Millhuff: So that would be one safety net to catch some of this if there's multiple psychotropic meds including a Benzo that's on board.<br><br>Dr. Zhou: Well we will have to look into the Benzo cause I don't know if that is in the algorithm.<br><br>Dr. Millhuff: Well the PMUR that Texas has which I understand is sort of the model for that doesn't include Benzos in their list. I think they list a certain number of psychotropics but I'm just curious would the other managed care organizations do you have any other sort of; how would you catch an outlier that's maybe using a bunch of this drug class in a pediatric case. Does this sort of pop up on your radar?<br><br>Dr. Murff: Well we have what we call retrospective drug utilization review programs and so those do look for what we would call polypharmacy or duplicate therapy within various classes. And so what, in that program is, it's an identification program and then it notifies the prescribers that there are multiple prescribers they each get a letter and then they get here is what your patient you know the duplicate therapy that we are seeing, polypharmacy.<br><br>Dr. Millhuff: Right.<br><br>Dr. Murff: So it's really more of a notification to the prescribers but then we do also kind of eyeball the data and look for outliers that may benefit from direct outreach from our clinical pharmacist.<br><br>Dr. Millhuff: Corrective, experience; so great. Okay, good.<br><br>Dr. Klingler: And there some uses you know, with Idiopathic Torticollis, Valium® is the documented treatment of choice. So there are some legitimate pediatric uses for some of these. You know about once or twice a year we'll see a kid that's got Idiopathic Torticollis and two very, very low doses of Valium® and that's relieved but it's a pretty specific indication for the use of that.<br><br>Dr. Porter: You know one thing that all through this process has struck me, is that in a way that the MCOs and KanCare, there, you guys see the outliers and you have been reaching through the | |

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| | PMUR or other programs, we get notifications here or there if something is; but it really hasn't had a lot of teeth to it. I think most of what we are doing here is by casting a broad net and putting these utilization reviews in place, we are trying to catch the people that are doing something that's harming a patient. It's almost as if we could give those more teeth that if somebody couldn't clinically explain themselves and didn't wouldn't make a change that it would go to the Board of Healing Arts and you know you're opinion about them being out of bounds and harming a patient versus their opinion. It would either take on a the real trouble people rather than sort of casting this broad net which results in some excessive insufficiencies in our mental health centers and other clinics. I realize we're not going to change ground but there just seems like a great opportunity for you guys to see the really bad things and do something about it. Anyway, I didn't have a follow up; just a vent.<br><br>Dr. Mosier: Were any other looks at the data? I think we have quite a few defined. But anything else that you could think of that would be useful in your analysis for next time? And what we'll do is, we'll get that data as soon as we get that out we'll send that out so there can be some online discussion about that. Alright with that we will take that information and I guess the other piece of that we talk about the criteria where just its doses exceeding this and the prior authorization and when would require the written oral or oral peer to peer review with the help of psychiatrist and medical director pharmacy director for approval. Any issues with that particular item as long as we're on this?<br><br>Dr. Adma: That language is consistent with others, so it's fine.<br><br>Dr. Mosier: Okay before we leave new business, obviously there was some email traffic about PDL and I wanted to bring up kind of what the scope of this committee is and kind of committee structure and that may alleviate the concerns. But we have the Drug Utilization Review Board which is the, in essence, the decision making body. Go ahead.<br><br>Dr. Millhuff: I'm sorry to interrupt you, but can I go back to one more thing under this last piece of business?<br><br>Dr. Mosier: Sure.<br><br>Dr. Millhuff: I, I've noticed that the length of approval on these policies is 12 months and I just | |

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| | wanted to ask why do we have that length of approval if, if, let's say the medicine that has been prescribed has gone through a PA process. Let's say one of these, if any of these meds that we've developed a policy for why do we do another review in a timeframe of 12 months versus just saying it's been approved for the life of that drug we'll continue; it's approved for this patient and call it good?<br><br>Dr. Adma: That's an interesting thought. I never thought about it.<br><br>Dr. Zhou: Operationally speaking it's kind of the standard of how, I think, those prior authorizations are entered within the computer systems. Because if you do a, I guess, indefinite prior authorization then if any changes are made to the policy in the future we won't be able to go back and look for those prior authorizations and then make, you know adjust those prior authorizations. It's generally easier to do prior authorization within a certain timeframe and then if any policy updates are adjusted then the prior authorization will be reviewed based on the new criteria when the time is up. So I guess there is a slight difficulty in the implementation versus ideally what would occur.<br><br>Dr. Murff: There is also renewal criteria that you typically addresses you know, the patient is doing well on therapy and one of the things that I really think it catches a lot of times are the patients that they have been DC'd; the physician has DC'd the medication, but the pharmacy continues to fill it and the patient frequently is; you'll also sometimes find that where the patient is on some of that duplicate therapy, is they just never DC'd the med like they thought they were supposed to so that your prior auth. keeps that it check as well. That yes the patient's doing well and we want to continue on the medication and certainly the renewal criteria you know when you have a patient that's established on therapy then that's a completely different review then it would be for a new start. You know where there's more criteria that we are looking at the reviewer really is just looking at are they filling it consistently at the pharmacy, are they you know doing well and that's really how a renewal would be versus you know an initial prior auth. So it's not like you're going through that same prior auth. process year after year it's really more of a, the patient's compliant and the patient is doing well.<br><br>Dr. Millhuff: Okay. So my greatest concerns are gaps in treatment and the patient's health and the administrative burden of doing this stuff and I got this question from looking at this consensus statement from American Medical Association and a bunch of other medical societies. It is titled | |

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| | 'Prior Authorization and Utilization Management Reform Principles' and I will forward this to our group if you want to look at it. I don't think the MCO folks were on that. But they raise that as one of the recommendations that they gave was principle number six prior authorization approval should be valid for the duration of the person's prescribed/ordered course of treatment. So I just raise that as a question to our group for consideration in terms of the items that I just mentioned a moment ago.<br><br>Dr. Adma: Is this a national standard that the MCO's follow? Is this something across the board through their system? Or are there some states where maybe the time duration is more than a year?<br><br>Dr. Zhou: I would say the standard is a specific timeframe because of policies are generally continuously updated and renewed so that's why they want to make sure the new policies are applied so in this case it depends on are we every going to update these policies. That would be a consideration.<br><br>Dr. Adma: I guess then the follow-up question would be is it going to be twelve months versus can it be 24 months or can it be longer than that? Is there, if there's a timeframe that is required?<br><br>Dr. Zhou: I would say there is a possibility but it would be a little bit tougher in terms of human error because our reviewers are so used to seeing a specific timeframe that there may be times where they would not think ok this one I need to do at this timeframe versus everything else more than used to. So it could be a little more difficult.<br><br>Dr. Todd: And I think that some of it probably from way back when, you know, is maybe mirrored around the idea the prescription itself unless it's a controlled substance is good for a year from the date it's written and the idea that if you're going to a general practitioner you need to go in once a year. You know and do your well-being checkup, right? So, I think a lot of it is just kind of geared around you know you go to a doctor once a year, you go; it's not specific to mental health, you know but.<br><br>Dr. Porter: I agree it's a problem when we have, when we don't close out old prescriptions. As physicians sometimes it takes a phone call sometimes our EHR on non-controlled substances does it automatically and it's a problem. I've seen patients get, they don't they get a bunch of pills and they're taking one that you thought they weren't taking. | |

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| | Dr. Todd: Sure.<br><br>Dr. Porter: But, I also don't think this, I think the prescription runs out the same time the review is due. So I don't think this adds an additional layer of protection against that problem by having an annual redoing of the prior auth, because, again, the script if it's controlled at 6 months or 12 for the others. It is, but you are probably right, it is a problem.<br><br>Ms. Perry: If they change doctors every few months and every doctor extends it for a year then you can have an ongoing at some pharmacy. They can have different timeframes and I'm with the I did prior authorizations for several years it, the year timeframe catches a lot of those gaps changing doctors, changing pharmacies, multiple doctors that they forgot to tell them. They moved now they go to this doctor who is now prescribing this but they've forgotten so other pieces like this they don't always tell you what all they are taking and that year review tended to catch a lot of those things. And again the renewal review is basically, are they consistent; is everything ok; are they doing well on it. So it's a better, easier review.<br><br>Dr. Millhuff: That's helpful feedback. And so we don't define what the length of the approval and what the review will amount to in this policy. I mean this is news to me. I don't know how this is going to play out with the policies we've already approved. It just says length of approval is 12 months. So I would assume that I'm going to have to go through the same full set of criteria for each approval.<br><br>Dr. Zhou: Every 12 months.<br><br>Dr. Murff: There are; some of our policies actually do have renewal criteria and I think in our antipsychotics…<br><br>Dr. Millhuff: Correct.<br><br>Dr. Murff: …children and adolescents.<br><br>Dr. Millhuff: Yes. | |

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| | Dr. Murff: We sort of changed that to make it so that it is a much less cumbersome process when it is a renewal and I would assume that with this criteria, sine it's really very basic… some of the basic criteria; the renewal. I mean and that and when I say looking at the compliance that's something that the clinician will, our clinical reviewers will frequently do just because they have that claims data and they can see that. So that's an important factor to have the discussion if the prior auth is being requested as a renewal and there, this patient hasn't filled it for 6 months. Maybe we need to make sure that this is, you know, that the prescriber is aware because maybe the dose is being increased or something, you know, but by the way, we don't see any claims you know on our end. You know a good point of discussion not necessarily a reason for denial but it's just that some of what they look at in a renewal.<br><br>Dr. Todd: But this specific criteria keep in mind is a little bit different than just clinical criteria. Like having to meet a certain diagnoses and such. This is really, if you are exceeding over the limit; if you're prescribing you know if you're prescribing 100mg of Alprazolam then it's going to deny and we're going to need, to need to review it. But if it, but if you guys said that it's 6mg and your patient has 6mg or less it's not going to stop for any kind of review, it's just going to pay. It's a little different. It only requires PA or review if the limit is exceeded. Otherwise the claims are just paid they're not going to stop. Does that help?<br><br>Dr. Millhuff: Yes it does. I'm just trying to represent my peers.<br><br>Dr. Todd: Sure.<br><br>Dr. Millhuff: Who, one of the primary concerns is the administrative burden, which at the beginning Dr. Mosier you said you didn't want this to become overwhelming to prescribers and so the turnaround on the PAs; I think we are seeing some new things that I think are really going to be good to simplify that. But I know that, in our little clinic here in Topeka, we've got the pharmacist in our clinic said that she's anticipating 100 clients who have been grandfathered on these antipsychotics suddenly coming due for PAs and so there's sort of waves of administrative work that I am concerned about in just trying to weigh how these policies affect the already very busy caseloads for prescribers taking care of psychiatric patients.<br><br>Dr. Porter: The abbreviated, I guess, prior authorization renewal that Ms. Murff was talking about, is that the same across all three MCO's? Or is that just a United thing? | |

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| | Dr. Todd: I mean, we just use the criteria that is approved here, then through the DUR.<br><br>Dr. Porter: So you're saying yours would be the same as the original one?<br><br>Dr. Zhou: I would say if you are interested in having specific criteria please do add it to the policies. It would be easy for us too.<br><br>Dr. Porter: I was just, we were just hearing something that sounded less, like less work. I don't know if it would be, but as long as it's not a phone call, that's not too bad. But, the something about you just made a statement, this patient's stable or something like that which is different than redoing all of the items on the PA. I was just trying to get clarity on when it comes to a year and the review, what would be the; what will the clinician or the clinic receive? What will they need to do to get that completed? I think it sounded like maybe you guys do something a little more abbreviated on some and you guys would give us the same prior auth form back.<br><br>Dr. Zhou: I would say we would give you the same form but we direct our reviewers to be, I guess, more clinically lenient if a patient is stable on a medication. We tell the reviewers to just let it go through. But again its individual reviewers and we try to do our best to keep them on track but I would have to say there are times where I felt like my reviewer has reviewed inappropriately and we have educated them on how they review certain PAs.<br><br>Dr. Mosier: So I think to this point and the potential of adding renewal criteria, when we're looking at this specific proposal what would be a reasonable set of renewal criteria based upon your experience?<br><br>Dr. Zhou: I would say patient is stable on current dose would be appropriate.<br><br>Dr. Todd: So the current high dose, whatever they were approved for is that you are saying?<br><br>Dr. Mosier: Yeah because it would have to be above the approved amount, you're right.<br><br>Dr. Porter: And some of these aren't necessarily dose related, but age related, like what's going to hit Chip's shop over there. A bunch of kids who need this medicine and had to go through a prior | |

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| | auth; they're on an atypical; there will be a 100 of those coming up.<br><br>Dr. Millhuff: Right.<br><br>Dr. Porter: Next month or so.<br><br>Dr. Millhuff: I just want the committee to know that I have colleagues in community mental health centers that are telling me that they have patients that are going without medicine still, because of the PA process. And so then you have patients that are falling apart, ending up in the hospital. These, in my regard, I just don't want to do any harm with these policies in terms of the administrative burden. That's why I just question whether or not we might consider, as we are moving forward, approving these criteria for the length of the prescribed medicines. I think you have raised some good points as to why you do a review but what you just described to us of yes the patients still on it and yes they're stable, but it seems like busy work to me to be honest with you. If you see my prescription and I've renewed it and you then pull the record and see that Dr. Millhuff did a write-up about that patient encounter that's legitimate. It seems like that would be adequate.<br><br>Dr. Grinage: I wouldn't think, that doesn't mean that you MCO's you couldn't review and if you see that it hasn't been filled then you reach out to the provider, you know, and provide feedback. I think the insurance companies can review all they want. Yearly, if they want.<br><br>Dr. Millhuff: Well it's like what you were just mentioning, the PMUR, there's other safety nets out there. Do we have to have this defined in our policy here as having just a length of approval?<br><br>Dr. Friedebach: Well I think what Jennifer and Angie were both speaking to is often times our prior authorization criteria has specific renewal criteria that basically allows for that circumstance. Where the renewal criteria may be has been seen by the provider in the last 12 months; has been stable on the medication. It depends on the medicine and the dose and what you're trying to accomplish. So if the committee really feels like the dose of Benzodiazepine they set is going to be safe for a minority of patients, they're really going to hit that at a part of outliers, we should think about very carefully. Then the renewal criteria may include something like tapering has been attempted and has been unsuccessful; documentation of that. So whenever you think about that prior authorization criteria and that renewal criteria you have to think of it in the context of what | |

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| | are you trying to accomplish? So if you're trying to accomplish the drug is clinically appropriate; a two year old should have an antipsychotic because of this diagnosis that maybe doesn't change, right? But, if your prior authorization criteria is saying this dose is rarely ever appropriate, and quite frankly, we think it is dangerous, well then you may want to look at it every single year for all of the reasons that you pointed out. That things happen, and that there's variation in care, and people slip off the map, so to speak. So I think I would encourage you to think about this criteria and what you are trying to accomplish and if it really is setting a safety bar and you are saying people over it are in potentially dangerous waters then you may make your renewal criteria in there saying: they've been with the same physician; tapering has been attempted; they've been seen in the past 12 months. I mean your renewal criteria can be check, check, check, and often times when we look at prior authorization criteria what you see is the criteria for the initial approval and then the renewal. Now United, Amerigroup, Sunflower may have different perspectives, philosophies where they are a little bit more, their reviewers look at things; and all reviewers look at it from the perspective of their experience and their training. But, concretely speaking, when you put a renewal criteria in, if you like the way that looks, that will be consistent and across all. When these things are in place it approved so that's the one thing to think about in this regard.<br><br>Dr. Porter: We took, I think, a pretty thoughtful and aggressive stance about metabolic labs in young people. And that's where this really, I think, really, that's where this is. If you look at the number affected, that group the 13 to 16, those groups have the highest number of affected recipients. We do want to make sure people do that once a year; people get metabolic labs. So on that one side, it's our function to remind and monitor that that people's metabolics are being checked. The annual review makes sense. At the same time, that's not quite as a dire of a situation that you were talking about that's one case in the State. I think some of these approach thousands or hundreds, easily, of cases. Almost all pediatric cases. Where we're not just picking up, kind of, the dangerous dosing. We expect proper monitoring. Which is actually being done by a quarter of the cases nationwide. At least in the adults. So I think that's the big decision for the Committee. Do we keep, do we, if our goal is to maintain that metabolic monitoring, then annual review makes sense, but the burden of such a check is high in most cases.<br><br>Dr. Adma: So what we are talking about is, maybe, is having a renewal criteria for the Benzodiazepines?<br><br>Dr. Porter: Or just renewal criteria in general is on the floor, right? | |

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| | Dr. Millhuff: I just raise the point because it's a part of the prior authorization criteria here, as we think about this between now and our next visit, maybe, it's not anything I can remember us talking about in terms of renewal criteria. Except for where when we specifically delineated.<br><br>Dr. Mosier: We had them on antipsychotics; we had them. I think a couple of things that we can do, one is look to other States and see what their renewal criteria are and two, talk with the Managed Care Organizations and find out what they've seen in other States as well and bring that back as one of the data points back for you to look at.<br><br>Dr. Porter: There's one thing about when we look at other States, I don't, I think this is a little unique. I think most other State's criteria have been able to be put into place without being pestered by a bunch of psychiatrists and other clinicians as far as what we think we'd like. And so that is also our opportunity to do something that maybe other states... I, I, I'll always, I think it's fine to look at them, but not all of those might have been as clinically informed people in the state as what we have here.<br><br>Dr. Mosier: I understand there's like a strawman, just like you proposed, 6, 8 and 8, but open it to the group. That's for you to discuss and decide the appropriateness, absolutely<br><br>Dr. Millhuff: What I'm wrestling with, is how much do we manage this? How much do we manage the prescriptions here of these different drugs? And Ty, you brought up the thing about laboratory monitoring. I mean, we've only focused on the pediatric population, but it's clearly a risk in adults. We've not created any criteria for adults. Not that I'm suggesting that we do that. It's just, were do we sort of draw the line with this? Why are we focusing on in certain ways versus others? Do we have good, logical, clinical evidence and practice support to do what we are creating in these policies?<br><br>Dr. Mosier: As we talked about in the very beginning, and you brought up kind of the gutter or the alleys, right? We're trying to create these areas where we have the greatest safety concern, right? So we are looking at that. Want to set it in such a way that was kind of balancing, absolutely the safety but also the reasonableness of clinical practice and making sure that it struck an appropriate balance. I think that a different group of people, each individual may said it slightly different but I think that we benefit from this group sharing their experience in coming to a reasonable consensus | |

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| | around the practice that we do here. And I do agree. I think it was you Dr. Porter, that when we were having the meeting that we were discussing forming this, and you were like, 'Really? You want all clinical people?' and I said, 'Yes, absolutely.' for this very reason. I don't know if you remember that, but it was interesting. We didn't want, we wanted all the people on the front lines who could address this. That's, in my opinion, the beauty of the process. And the messiness, too, as the case may be.<br>Alright, anything else on that? We'll have, obviously, another chance to talk about it. There will be data in between. So time to talk about it via email and then at the next meeting as well. That's what we wanted to do is get the ball rolling on the new business. But new business is meant to come back for at least one other look at it before we make the final decisions. | |
| IV. Open Public Comment* | **Clinical Public Comment: -** No requests were received.<br>Dr. Mosier: We don't have anyone scheduled for the open public comment.<br><br>**Committee Discussion:**<br><br>Dr. Mosier: I think the other thing that I was just going to talk about was the Committee structure in terms of; we have the Drug Utilization Review Committee. So as things come to this Committee, the Mental Health Medication Advisory Committee, to look at the clinical criteria, that then goes to the Drug Utilization Review Board. The Drug Utilization Review Board can either improve and hold, and if they don't, then it comes back here for review. So they don't get the opportunity to modify anything. It's what this Committee recommends or not. There is actually another subcommittee of the Drug Utilization Review Board and that's the PDL Committee. I think there was some question about PDL but that's actually the purview of another Committee. It is covered but it's via the PDL subcommittee.<br><br>Dr. Adma: So are the members on the PDL Committee, I guess, some are they members of the DUR Board? Is it different?<br><br>Ms. Grant: It's a whole separate Committee of different physicians and pharmacists.<br><br>Dr. Adma: So it's separate. So we have the DUR Board, which is separate. And the PDL Committee, which is separate.<br><br>Dr. Mosier: And the Mental Health Medication Advisory Committee, which is separate. The | |

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| | subcommittees are similar in feeding advisory boards to advisory bodies.<br><br>Dr. Porter: Was there a procedural misstep to have us vote on the PDL?<br><br>Dr. Mosier: Yes, it was. Sorry to confuse the issue.<br><br>Dr. Millhuff: I have to comment, Brad, I'm not trying to pick on you, but he just said to me 'What's PDL?'<br><br>Dr. Porter: That's what happened to us.<br><br>Dr. Millhuff: This is what happened in our meeting some time ago. The meeting you missed. In fact, Karen, you and I were asked that question. But it came after a very long discussion. It was just a handful of us here that day and I know that I raised the question in email communication as to whether we could spend time like today to understand this better. Because all I really remember learning is a preferred drug list and there was one little slip in there about non-preferred. You know, it's just my naivety to this kind of discussion and I didn't ask more informed questions.<br><br>Dr. Klingler: Could you review the purview of that Committee for us? Because I think we all have a fairly minuscule understanding of their role.<br><br>Dr. Grinage: Or even the organizational structure? So is the DUR Board over both of these Committees?<br><br>Dr. Mosier: Both Committees are advisory to the DUR. And then the DUR is the decision making body that moves things forward. The structure, like the structure of this Committee, is defined in statute as is the DUR, as is the PDL Committee. So, for instance, for this Committee, the exact make up; the size of the committee; the make-up of the committee; how often we meet; all of those things are defined in the statute as is the PDL. I don't know all of that off the top of my head. So what I would recommend is that we bring that back as an action item to do an educational process for the next meeting, if that would work for you.<br><br>Dr. Porter: The following question might be part of that. I think we've had a little bit of back and forth… One of the other laws changed a year or so ago allowing step therapy also for KanCare. | |

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| | I've heard different things. Maybe that would be our next assignment for this Committee or maybe not. The other thing I wondered would be, PDL seems kind of like a step therapy to me. How is it that that; I guess if it was supposed to go through us, it didn't. And how, if, I think you're seeing the question I'm trying to formulate. If we're going to get step therapy, how is PDL different from a step therapy? We're using certain medicines used for an expense reason, I assume. You have to try other things first or do a prior auth. Maybe I'm not forming a good question.<br><br>Dr. Moeller: I think I understand. Because I thought part of our Committee, at one point, we would get to say, you know, you must try generic anti-depressants before you try a brand name.<br><br>Dr. Porter: That's step therapy.<br><br>Dr. Moeller: With step therapy I thought that's how it would be down the line.<br><br>Dr. Friedebach: Step therapy is really the drugs that are not therapeutically equivalent. There may be exceptions. But I think of it as like, you need try an ACE before you'd use an ARB. Similar indication. Not completely therapeutically equivalent drug classes. Both are hypertensives, but a little different. A preferred drug list is going to be like all your ARBs. Okay? They're all arbs. They're all therapeutically equivalent. Then which is a preferred ARB and not? That's kind of the way I would think of those as a little bit different. I don't know, maybe. That's just in my mind. That you are stepping through to something that isn't exactly therapeutically equivalent in class but has a similar indication.<br><br>Dr. Porter: I think the big thing for us, with the PDL, that are impacted are the people that take care of kids. I'm just thinking. We're not really part of the PDL, but we did talk about it in here a little bit and we've learned more about it since. It's considered therapeutically equivalent, but the ones that are prior auth. are the chewables and liquids. I think some of the other things on it I could care less about. I can't think of anybody who's using those other than somebody that is very young or developmentally unable to swallow. So it's kind of like having that as a non-preferred drug, unless you guys have data that either, they're some providers out there giving liquids because people like them or something. I think it's creating a; it's basically kind of getting that group of people, the younger, or developmentally, or physically damaged people sort of another obstacle to carry that I don't see a reason for that. Because if they can't chew, they're going to go do the prior auth. They're going to have to take the time to do it and delay the medicine. So it doesn't really change | |

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| | any expense. It just adds a hassle in for those particular individuals.<br><br>Dr. Friedebach: I think there can be more review, but I believe the preferred drug; the PDL committee would be the ones to.<br><br>Dr. Porter: I understand. I appreciate being able to talk about something that isn't any of our business. It really affected…<br><br>Dr. Millhuff: Ty, it is our business because it was brought to our committee and we voted on it. How is it our business, why did we vote on it?<br><br>Dr. Mosier: It was a mistake when we brought it to this committee.<br><br>Dr. Porter: That's what she said.<br><br>Dr. Millhuff: Okay.<br><br>Dr. Adma: Would it make any difference? Would it be helpful for us to know and maybe PDL to know the structure of this committee? Who sits on the committee and maybe how they made the decisions that they do? Maybe having some kind of meeting or would it be counterproductive? Do you want this to be two separate committees? What's the thinking behind two separate committees? And then no interaction between any of these, whether it be DUR Board, us and?<br><br>Dr. Mosier: I think a couple of things we can do, and one is, we can go through the statutory requirements but they are two separate and distinct committees with different charges. I think just clarifying around that. The question that you raised around the, here are these people that need a different form, in order to get that, and removing that barrier. We've placed that barrier, how do we remove that barrier is a very valid concern and something that should be taken to the committee to look at. But it is the purview of.<br><br>Dr. Porter: I'll try a motion and see what happens. I move that we make a formal statement from this committee that we disagree with the non-pill items on the non-preferred drug list.<br><br>Dr. Mosier: Well, I'm going to… So the… You don't have the statutory authority to do that. | |

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| | Kansas law presides. But we can certainly take that into…what's that?<br><br>Dr. Grinage: I told him to quit breaking the law.<br><br>Dr. Mosier: But we can certainly take that information and forward it.<br><br>Dr. Grinage: So this is like; the PDL is formulary restriction, and it includes methods of administration, types of medications. They choose which is higher on the list, is that it?<br><br>Dr. Friedebach: I think this, my understanding, and correct me, and Angie, you can speak to it; they determine if it's therapeutically equivalent. So if you're looking within that class of Benzodiazepines, they will say there's no research to support that this Benzodiazepine is much better than this. So the Benzodiazepines are therapeutically equivalent. So that's what the PDL is tasked with. From my understanding. I think you have a whole infrastructure that determines therapeutically equivalence. I think there would be a good opportunity to say they may be therapeutically equivalent but in the preparation indicated for this age group, this needs to be considered. I don't know the avenue by which they've given that committee the feedback.<br><br>Dr. Klingler: I don't know, we're scrolling thru the PDL stuff over here and for instance under the SSRI's Celexa® is preferred, Celexa® Solution is not.<br><br>Dr. Porter: It's just the form.<br><br>Dr. Klingler: Same, yeah, and so it's within that class it is entirely the delivery method on that one whether it's approved or not.<br><br>Dr. Adma: That might be because of the cost base.<br><br>Dr. Friedebach: The PDL is saying they're therapeutically equivalent and then the state is saying this is the preferred med.<br><br>Dr. Porter: If you can get it in your serum form, if you can get it in your body.<br><br>Dr. Klingler: It's kind of like trying to give my kid with pulmonary hypertension a tablet when | |

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| | they're 6 months old versus giving the solution. It doesn't work.<br><br>Dr. Grinage: Yeah, and this is the, I mean, this isn't uncommon for other pharmacies for cost savings purposes, but I think what the therapeutic equivalence doesn't take into account is side effect profile with certain patient populations. Maybe therapeutically equivalent but there are reasons why, and that's I think been a vain to physicians trying to talk to pharmacies and how to prescribe, describe why they want, a crossbar. That happens in the VA quite a bit as well, so sounds to me like statutorily, this is the committee that does that. It would be nice to be able to figure out a way to communicate our thoughts, but I don't know.<br><br>Dr. Moeller: I guess as a public comment? You'd have to make a public comment to the PDL. I would assume, I think one thing to think about though too is you talk about the Celexa® and the solution thing, saying that they're equivalent. Most people and other insurances, they're probably have the same, preferred and non-preferred it doesn't mean they can't get the solution, it just means there's a prior auth. Probably all other insurances is probably very similar, I would guess. And if we went through that PDL and we looked at other drugs, and other like hypertensives, I can't think of other solutions off the top of my head. Ibuprofen, you know, things like that, that there's other classes that people are going to be saying the same thing that I have a kid who needs this hypertensive in a solution and it's the non-preferred versus the preferred.<br><br>Dr. Porter: In this case, Celexa®.<br><br>Dr. Moeller: What I could think of as special, the cardiologist are going to probably think the same thing.<br><br>Dr. Porter: This is what happens why you have to let us in. So we're going to tell you how things affect us. We just have to take the other insurance companies for what they do to us. And we're part of the discussion right now so we're going to give our 2 cents on it and every just do a PA, well you know I had a kid who metabolized his long acting Methylphenidate rapidly, and it wore off at 5 and he's hitting people, and he got on 2 of them a day and he was great and but obviously this was not a twice a day medicine so I had to do a PA. But I had to take a half hour away from taking care patients to do that PA. And this attack and/or the tax payers are paying mental health centers to have extra staff, whose job it is to handle PA's which are not just Medicaid obviously, we're going to have them regardless of what we do here but to the mental health centers it adds a | |

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| | whole bunch cause that's where Medicaid goes. We're going to keep trying to be flies in the ointment and slope and minimize PA's whenever they seem unnecessary. And again, if you're asking for a chewable, I know we're not PDL, but just for the example, if you ask for a chewable you probably need a chewable. So you're going to spend this half hour or whatever saying, this patient is 5, she can't swallow pills and needs a chewable. And that just took….<br><br>Dr. Moeller: We just looked at that that, at our formulary and most of our pills you can open up and sprinkle on food. And so…<br><br>Dr. Porter: There's about half of the ADHD medicines.<br><br>Dr. Moeller: A lot of them can be.<br><br>Dr. Porter: Not all.<br><br>Dr. Moeller: So, there's a lot of brand new ADHD medicines that are coming out that are just the different formulation.<br><br>Dr. Mack: Most of the prior auth. rationales are on the paper that we get that doesn't require a peer to peer unless there's not enough information to submit on the form.<br><br>Dr. Porter: This was a dose. Actually, a different situation. It was a not under ours or the DUR but dose optimization. So you end up talking to a pharmacist trying to explain why you're giving this clinically.<br><br>Dr. Mack: It shouldn't require a phone call. It is burdensome to have to write your rationale out but shouldn't require a half an hour. In most cases.<br><br>Dr. Porter; It is hard for us as clinicians to keep separate all the different review processes we have. I know the dose optimization is just a flat denial phone call and I'm not sure what all these will be. But anyway, I've had my time.<br><br>Dr. Mosier: Anybody have anything else before we adjourn? | |

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| | Dr. Adma: Dr. Mosier, thank you for being able to say that maybe next time we will know exactly what will be the functions of this committee and we'll have a better understanding of what we need to focus on and get things done. One of the things I wanted to find out also was, maybe next time you can have answer is... How long, is there a timeline for this MHMAC to be existent, is it an ongoing kind of process or?<br><br>Dr. Mosier: What's that?<br><br>Dr. Adma: We've been doing this for about a year and a half or two.<br><br>Dr. Mosier: Right. In the…<br><br>Dr. Adma: What was the vision?<br><br>Dr. Mosier: As I recall there wasn't a sense that in the statue itself, however there are terms so, I think the first renewal already came up for being on the committee, so it's something where obviously there's a huge time commitment for you all to do that. So it's something where if you've served to the term and there's a desire to let your, whoever nominated you, if it's the Kansas Psychiatric Association, or the Association of Community Mental Health Centers, that's an opportunity obviously, there might be reason to do it in the middle of a term. Typically what we asked for was that they provide 2 names per position on there and then one person is selected for the committee. There wasn't, as I recall a sense that, I'm trying to recall, we can certainly bring that back. I think that the majority of the committee's work, were getting thru almost all of the drug classes, so it would be the kind of thing where there might be additional medications or additional changes that could be but that is a really good question in terms of is there a natural life, if you will, of the committee, but in my recollection is that you are term limited as a person on the committee but the committee its self does not have a sense of.<br><br>Dr. Adma: Yea, it would be helpful for us to know, the other thing is we are making all these decisions and then it's going to the DUR and then they are being implemented. There's always this thing in back of our mind, how is it impacting in a positive and we're doing this for the betterment of the patients and all, right? You hear some of us complaining, well it's increasing the time that the doc is spending or the secretary is spending and all. I'm hoping there's something positive coming out of this decisions we are making. So I think it's helpful for us to hear some feedback | |

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| | about some of the positives that's coming out of this so that would help us, you know, moving forward, saying, ok there are some challenges, but at the end of the day it's helping improve patient safety, reducing the number of hospitalizations, or whatever that data is. It's always helpful for us to get that kind of feedback. Some of it may be hard to collect, but it would be helpful.<br><br>Dr. Porter: Easiest to see if any of these things that we are measuring went down.<br><br>Dr. Millhuff: Right, that's what I want to know.<br><br>Dr. Mosier: Very good task.<br><br>Dr. Millhuff: So, Annette, if you were to look back at some of the data that we were presented by the first pharmacist on the committee, what, how has that data changed?<br><br>Ms. Grant: I do have 2015 to 2016 with the, here, if you would like to see it. You know with each policy patients that were grandfathered so you don't really see the full benefits, but there are some changes back and forth.<br><br>Dr. Millhuff: Well just looking at it, is there anything substantially different in prescribing patterns.<br><br>Ms. Grant: I didn't see any because the numbers, some were increased, some were decreased, some were all over, but like you said there's a lot of grandfathering going on so you can't really see until all the grandfathering's done you won't see as great impact of the changes.<br><br>Dr. Porter: Is there kind of an industry timeframe that makes sense to look at, like a year or 6 months that we expect change or is that an unknown thing?<br><br>Ms. Grant: I guess I would say 2 years after you've started, because then it allows the year of grandfathering's to be done.<br><br>Dr. Porter: 2 years?<br><br>Ms. Grant: Once the grandfathering is done, then you would see a year from that, which would be two years after initial. I would think that unless you have another suggestion. | |

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| | Dr. Millhuff: I don't know. This is the role of like pharmaco-epidemiologist or something, which is really kind of interesting. But I, along these lines, I also wanted to say that I noted in your email to us Annette about the comment about the 5 day period since that's a new thing since our last meeting which I'm very pleased to see that. So hopefully we don't have gaps in coverage. Do people kind of get what that's about? Yeah, and then I just wanted to ask you if you could comment a little bit about the issue of trying to make sure each of the MCO's are using, help me out with this.<br><br>Ms. Grant: Sure. Yes, ok. So this is, this is, see if we can make it bigger, this is the KDHE pharmacy website, and you click to Prior Authorization so we do have a universal clinical PA form that is just a generic form where you can write the drug and different things on there. For any mental health or other, any kind, just a generic form. Then you have the, a universal non preferred PDL PA form. So those are our 2 general forms that are basic for those items. They're not specific. So if you go down to the 3rd one, drug specific clinical PA form. So Nancy if you could click that for me. This is where the provider goes to get their form. They're all alphabetical by generic name. If you scroll down, Nancy, to, I actually made; if you'd go down to the 'M's, if you go all the way down, I actually separated out mental health. So that when they go to these forms, you'll see mental health, and there's all the PA forms for mental health drugs. And so if you want to open up the Antipsychotics in Children and Adolescents, the one we just did, this is the updated document. So as you scroll down you have the usual stuff, but we put any criteria which is common for all ages, we just put it there so you could fill it out all at once. So the basic. And anything that was by an age, so this is the one for just under 4. Or just 4 to 6 years, those are the things, those two have a couple of the same but then the 6 to 18 are different. So anything that was different, are not, we put there. So check boxes, you know, we tried to make as simple as possible. There are a few forms where it says, an opportunity to have a written reason why they're doing this or that. And so, that can be faxed in and if the medical director says this makes sense to me they can approve it. So no phone call needed. But if they say this doesn't quite meet enough then I want a verbal, so we try to make any form that has what those little kids or whatever give the opportunity for a written first, so they write something in and they approve it then no need for a phone call. So try to speed that process up. We really try to streamline the forms, check boxes a few lines because I think Dr. Porter said well I might want to write a few things. We did put that in where appropriate. So we really tried to clean up all the forms. Nancy scroll to the top, so no matter which MCO you're working with or fee for service you have the phone and fax number is right there, so it's, it's all on | |

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| | the same form. So all MCO's and all fee for service use the exact same form if you talk about a drug specific form. So that the providers don't have to learn a different form for antipsychotics, you know, in children and adolescents < 18 years of age. Just trying to improve the provider's experience, not have to learn 4 different forms, and all the information you need, regardless of which one you need, is all at the top.<br><br>Dr. Adma: So, Annette, great format. Really like that. Have the MCO's done any provider education about this form?<br><br>Ms. Grant: I know some of them have, and when we did the universal that went out to all the, I guess we sent that to all the MCO's and everybody, but as far as the provider, I don't know that I've done that. But definitely could do that.<br><br>Dr. Adma: It would be helpful to do that. Maybe you can send it to us, maybe through KPS. Maybe use our medium and mental health centers can use their medium to produce some of the provider education.<br><br>Dr. Porter: I think this might be out of your guys' control, but how do you find out about a PA as a provider if you didn't know it was going to happen? You get a form from the pharmacy. All the different pharmacies have different ways of communicating stuff. It would really be good to say go check the website for the appropriate form.<br><br>Ms. Grant: We do have bulletins that go out, for any, on monthly updates on any new drugs that requires PA. Those bulletins go out to all providers. Providers means pharmacies, hospitals, doctor's offices, so we do send out bulletins every month anytime we have updates in PA's. So also each MCO, scroll to one of the MCO's, their website will have, so even if a provider is used to working with a MCO website and you want that PA form, it pulls right back to our website and there it is again. So, again, I'm just trying to work on streamlining, condensing, you know, improving convenience, actually in all the committees, PDL, DUR, and Mental Health [Medication Advisory Committee], I'm trying to clean it up and get it on the main pharmacy page, eventually, the more I get this to work the more I can promote it. Like this is our site, if you need anything, here's where you go. So, um, what else, so that's how they get to the forms, we've simplified the forms, what else. | |

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| | Dr. Millhuff: Let's say the pharmacy says you're going to need to do a PA on this patient, this drug, so the nursing support could pull this up, print it off, fill it out and fax it in.<br><br>Ms. Grant: There ya go.<br><br>Dr. Millhuff: And then what happens?<br><br>Ms. Grant: Well then it would go to; when you send to the proper fax number, depending on the MCO, they would respond. The clinical pharmacists, not these ladies, but the ones that do clinical PAs for them would look at it, see if it met the criteria and they would call the pharmacy and the physician to say it's either approved or denied and then they use a follow up letter after that.<br><br>Dr. Millhuff: Okay. So then we would be waiting to hear or the pharmacist would be waiting to hear about the approval?<br><br>Ms. Grant: Mm-hmm. [Yes.]<br><br>Dr. Millhuff: And so, is that accurate?<br><br>Dr. Murff: If all of the information is included on the fax, then the approval can be made just based on that fax. Then a letter would be sent to the patient; to the physician, and then the prior auth would be loaded over in the system so, and the pharmacy would be notified as well by phone.<br><br>Dr. Millhuff: Okay, so then, so what is the turnaround time once we've filled it out?<br><br>Dr. Murff: Twenty-four hours. We start the clock when we receive it. So we report that to the State. We track that religiously. So it's a twenty-four hour turnaround from the time that we receive that. The incoming fax is time stamped.<br><br>Dr. Millhuff: And then, let's say, in the meantime, whatever's going on as this is being processed, how does this five day piece come into the equation?<br><br>Ms. Grant: I have learned, actually, from talking to different pharmacists from different pharmacies and within, I think what happens a lot is when a pharmacy sees that, you know, you can give them | |

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| | three days and start the PA, their thinking that if they give them three days and then it's not approved then they're out that money. That's really not the case. I have discussed that with some of the associations and I do have a meeting in two weeks with the pharmacy associations again, so now that we've got some of this finalized, I will educate them again that we have a three-day and a five-day and they do get reimbursed if the PA is approved.<br><br>Dr. Millhuff: What was that last part?<br><br>Ms. Grant: I mean they do get reimbursed if the PA is not approved, they'll get reimbursed for the three days. If it's approved, then they fill the balance of what they already started. So either way, they are going to get paid for that. I don't think they realize that. That's an educational piece which I will take to the associations and make sure the pharmacies understand they will be reimbursed for that amount that they give at no charge.<br><br>Dr. Porter: What's the difference between the three and five? Why have the three?<br><br>Ms. Grant: Per CMS standards all drugs with a PA, you have to give them, actually, seventy-two hours now, a supply of medicine to get by until the PA can being reviewed. We did make mental health five days. So that's different.<br><br>Dr. Porter: So, mental health is a five day?<br><br>Ms. Grant: Yes. Only mental health.<br><br>Dr. Porter: Great, so that way you come out of the hospital on Wednesday before Thanksgiving and go to get your meds. There's a PA on it. You have a chance of staying on it.<br><br>Dr. Adma: What I'm also thinking is now that we have a universal form and there are dosing limits right there on the form and all, does it make sense for psychiatrists, nurse practitioners, use this more proactively rather than reactively? Which means, you know, it is part of their practice where they're seeing predominately Medicaid patients. You know if their prescribing something as they prescribe, and they know that it will hit the PA, they just fill out the form, fax the form or have somebody fax it. It's more proactive then you prescribe and then you wait to hear back. If they already know, like we do AIMS testing proactively. | |

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| | Dr. Millhuff: Correct.<br><br>Dr. Adma: This is one of the forms we have in our office as we're seeing patients. Through KPS, we can promote that.<br><br>Dr. Grinage: I know you're saying you're working on this, but I think we need to push this out to the KPS members. I would do that next executive meeting. Is that, this is up and ready to go for traffic?<br><br>Ms. Grant: Oh yeah. Mm-hmm. [Yes.]<br><br>Dr. Grinage: I think that's a good idea.<br><br>[Unknown]: And it's a public site.<br><br>Ms. Grant: It's public. It's our pharmacy home page.<br><br>Dr. Millhuff: And Annette, how do people become educated; how do prescribers; support staff, become educated about the five day?<br><br>Ms. Grant: The bulletin went out.<br><br>Dr. Millhuff: Just a bulletin? Is there any sort of reference to that?<br><br>Ms. Grant: Can you show the bulletin? I do have the bulletin if you want to see what the bulletin looks like.<br><br>Dr. Millhuff: Right, yes, but is it…<br><br>Dr. Adma: Is it on the form?<br><br>Dr. Porter: Some of you guys didn't look at your bulletins. | |

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| | Ms. Grant: Anyway, this is a bulletin. It has all four of the logos at the top of it and this is what it says.<br><br>Dr. Mosier: So we have a link for that on the website?<br><br>Ms. Perry: Most of them, I believe under the provider option, there's bulletins, manuals, and things like that. I know it is on the fee for service.<br><br>Dr. Mosier: Okay.<br><br>Ms. Grant: Do you mean on the pharmacy homepage?<br><br>Dr. Mosier: Yes, sure.<br><br>Ms. Grant: I can sure add that.<br><br>Dr. Millhuff: Yes.<br><br>Dr. Mosier: We can add a link on the pharmacy homepage so it would be easy, as you're showing this other, and say 'right here'.<br><br>Dr. Grinage: That's the education piece, that would be easier to push. Here's the link.<br><br>Ms. Grant: And as I get the things improved then I would like to promote it. But I'm like tweaking and improving…<br><br>Ms. Perry: And at the bottom it says it's in the provider manuals. Kind of hard to read up there. It does refer to that.<br><br>Dr. Millhuff: Thank you for doing that, Annette. I'm really impressed. It's good. Good work.<br><br>Dr. Porter: What's the… Is there any update on that gold card thing? I'm kind of lost on what the status of that is. | |

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| | Ms. Grant: Have we had any current discussions since we last spoke on it?<br><br>Dr. Millhuff: If I remember, Jonalan had mentioned some things about, and others had mentioned some things about, when we first debated this, who do we include in this group of people? And one question was nurse practitioners; do we include them as well?<br><br>Dr. Moeller: I think we heavily debated that. At the time, we had a debate about the nurse practitioners and we concluded not to.<br><br>Dr. Mosier: I think this goes back to what Dr. Adma said; we were going to get data and look at some of the changes based upon what we had and I think utilize that. We did say we were going to re-visit the gold carding and have a further discussion but, yes, we can bring that back.<br><br>Dr. Porter: What's the current status of it? Is it the same with all three MCOs? Where, where? I don't know where it stands. If there is one. I don't remember who it applies to, if there is one.<br><br>Dr. Mosier: All psychiatrists.<br><br>Ms. Grant: All Board Certified Psychiatrists. And the MCOs would have all the same provider profile for that.<br><br>Dr. Porter: Okay.<br><br>Dr. Klingler: And we added Pediatric Behavioral and Developmental didn't we? Pediatric Neurology?<br><br>Dr. Millhuff: We had that for the antipsychotics.<br><br>Dr. Moeller: We don't have that criteria spelled out.<br><br>Dr. Porter: So when you, Chip, you don't get a, if you have a child under, add medicines in one of our criteria, you don't get a prior auth?<br><br>Dr. Adma: I think the nurse practitioner, I think they need to be able, especially in psychiatry, it | |

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| | needs to be psychiatric nurse practitioner versus maybe a family nurse practitioner.<br><br>Dr. Porter: I think the other thing we have to consider, if we could just open it up for discussion real quick, would be, the psychiatric, especially outside the bigger cities, the psychiatric nurse practitioner are providing a lot of the mental health care. I'm guessing the majority, maybe you guys see the numbers, but it's a lot. Valeo, here in Topeka, 95% or more of the med checks/medical treatment is done by the psychiatric nurse practitioners. They have very little direct psychiatric time. That's one large mental health center. So when we don't include those particular colleagues on the gold card it disproportionately burdens those organizations that utilize a lot, again, mental health centers, really, so not only are the Medicaid people do go to mental health centers but the main provider is in the mental health centers are then not gold carded on top of that. And then of course, recruiting and retention to those jobs, which are demanding, gets harder. So I think the topic of nurse practitioners in general, and then psychiatric nurse practitioner, and then a smaller subset, probably the ones under the most pressure, are the psychiatric nurse practitioners in mental health centers.<br><br>Dr. Millhuff: Exactly.<br><br>Dr. Porter: Could all be considered different people to be considered for the gold card status. The last category, I think, really, the ones in the mental health centers, we really need to consider that again. Cause, again, all the reasons I just said.<br><br>Dr. Moeller: I think you rationalized it the opposite way last time. I remember you rationalized as you thought some of the criteria, some practitioners, you think the doctor should… be… I have reservations about extending it to nurse practitioners. I think one of us argued too, because if we extend it to nurse practitioners, I think you have to do Pas or physician assistants and I don't, I got a reaction from one people feeling differently.<br><br>Dr. Porter: One doesn't have to have a psychiatrist to, they don't have to be on a doctor's license, direct licensure directly…<br><br>Dr. Klingler: And the training is very, very different too.<br><br>Dr. Moeller: What is the training for a psychiatric nurse practitioner get? What additional | |

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| | pharmacology things do they do?<br><br>Dr. Porter: They just got their requirements to meet, Medicare requirements really increased. So I couldn't tell you, but I think it's about a three year program.<br><br>Dr. Adma: So, it's a two year program. They do one year of clinical rotations and all of it is in psychiatry. So they do some in child; some in pediatric; some in adult; inpatient; outpatient, and all that stuff.<br><br>Dr. Moeller: Preferably for me, just from history of seeing different prescribers, I mean, I think the gold card is so special, to me, about the gold card, that it should be reserved for the physicians. I think, you know, extending it to APRN or physician assistants, which to me, I don't see the difference between the two in prescribing. I think if we did one, we'd have to do both. I think some of the prescribing outside of the things that would may be coming from some of those. Because if it's in rural areas where they don't have much supervision.<br><br>Dr. Adma: And I agree with your thought. And the only thing, the only caveat to that is that there are some, the only comment to that is, there are some places which are disproportionally served by Medicaid population like community mental health centers. KVC, for example, has a lot of foster care children and we have nurse practitioners working there, and I tell you 99% of the patients that we provide in our outpatient clinic have Medicaid. So when you have that disproportionate amount of patient population that puts them in, and so do we, in those situations, say that 'unless by exception'? Or something like that so they know they're under direct care of a psychiatrist, that the nurse practitioner is working under your supervision. Right, so then they're always going to be those exceptions to the rule. Do we go in that direction? Be able to say, well, you know, do we gold card those psychiatric nurse practitioners?<br><br>Dr. Moeller: How many charts do you review of your nurse practitioners per month?<br><br>Dr. Millhuff: I don't supervise the nurse practitioners at our clinic, but I know that Dr. Atwood meets with them weekly and reviews their charts. And it's a regular, kind of supervised, process. Is that the standard? I'm not sure. He does review their charting and prescribing patterns.<br><br>Ms. Grant: Maybe that's where the data will help? You say pull data and compare it to what you, | |

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| | this Committee, has stated is the standard of care, and maybe it's provider by provider? This one is doing great and following what you determine is the standard of care and this one is not doing that, would that not be more fair in deciding who would and would not? If data is saying this one is prescribing safely and this one is not, regardless of their designation, you know, credentials.<br><br>Dr. Millhuff: Right.<br><br>Dr. Moeller: Isn't there a way to get to gold card? If you don't have a certain amount of numbers? Because I mean in general, there's good physicians, there's bad physicians, there's good pharmacists, bad pharmacists. You know. It's all over, you're going to have.<br><br>Dr. Porter: I know I said that I didn't think the fact that I'm a physician doesn't mean…I hope I'm good physician now but I might not necessarily always be.<br><br>Dr. Millhuff: But really, the gold card…<br><br>Dr. Moeller: There's different. There are prescribers out there that will prescribe 4. I've seen very interesting prescribing when people get admitted into the hospital, where I'm like, oh my gosh, who is the prescriber? Prescribing 4 of this or prescribing 3 antipsychotics and you know it's always going to happen. I know it's bad to single out.<br><br>Dr. Porter: This is opinion, not known fact, but when it comes to the excessive things you are more likely to get that from the psychiatrist than the nurse practitioner. They tend to be more cautious, in my experience. As far as multiple meds, that sort of things like in the criteria here. But I hear your point. I did say, you know when you talk about different things, talking about things that are happening thirty times in the State, you know that's different than something that's happening several hundred times, as far as how common the practice is. And so the ones that are in the real low number, I can't argue that any one of us should, gold card or not, shouldn't have to explain and then get in to the things that are hundreds of times; just a largely unnecessary thing.<br><br>Dr. Moeller: I just worry that if we gold card so much, then our criteria is pointless.<br><br>Dr. Millhuff: You know, Karen, one thought that I have in response to that is, I don't know all the details that led to this Committee being formed but, I know there's been a lot of concern about | |

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| | atypical antipsychotic meds being used in the pediatric population and that the signal for concern comes from, and then these meds being prescribed by primary care, no offense, but the idea that there are high numbers of that kind of prescribing practice going on. So if we gold card a specialist, would we, we'd still be accomplishing something by giving primary care some guidelines and education on how to prescribe these? And the other thought, along those same lines is, for instance if we were to ask the MCOs to consider advanced psychiatric nurse practitioners to be included in the gold carding, maybe with so many years of…I don't know what…some criteria with that. It could ease the burden particularly if we also made a criteria of or ask that consideration be given for community mental health centers especially in rural health centers because the demand is so high for their time. Ty keeps bringing up the examples of how clinic time is taken from him by having to do these things.<br><br>Dr. Moeller: I understand that but then I sometimes worry, the rural areas, the ones not being overseen. Are those the ones we are going to see more problems? And I wouldn't want the gold card…I think it's data, we're just assuming.<br><br>Dr. Klingler: Is there a way to get us data on how many denials have gone out and who those were given to? That would be a very interesting statistic to me in this discussion.<br><br>Dr. Mack: I can just tell you from the ones that I've seen, there's no discernable trend in those that were brought to my attention. BCP, ARNP, psychiatrists, these things occur in all classes of providers. There's no discernable trend.<br><br>Dr. Klingler: It would be interesting to see.<br><br>Dr. Mosier: I do think that when we did the analysis two years ago there were certain trends. There's anecdotal versus the aggregate analysis, we need to update that. We did it in 2008, well somebody did it in 2008 and then we did an update about three years ago. So it would be time to update that.<br><br>Dr. Moeller: It was one of our first meetings we looked at…<br><br>Dr. Mosier: Exactly. | |

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| | Dr. Moeller: Psychiatrists, and there were some differences on the antipsychotics and how many people were prescribing.<br><br>Dr. Klingler: And that's what I'd like to see now that our criteria are in place, and gold cards in place, what do those numbers… look like<br><br>Dr. Mack: That's the ones that have been triggered since this was put in place that have come across my desk, I haven't seen a trend. Just from personal experience.<br><br>Dr. Klingler: It'd be interesting to see numbers on that and compare those to the statistics. Because I think we all have gut feelings but I don't know if the data supports our gut feelings.<br><br>Dr. Grinage: I think the additional data was, there was for the outliers for antipsychotics were non psychiatrists. I mean, that's what really struck me.<br><br>Dr. Porter: I remember especially the younger users, it was a pretty small number too.<br><br>Dr. Klingler: And some of it is still going on, which is one of the reasons I'd like to see the data. I had a Mom of an eleven year old this week that or last week, that wanted her child diagnosed as bi-polar and put on antipsychotic medications. I said well you'll need to see one of the two psychiatrists in Manhattan that educate, or treats kids. She said, well they won't do it so I'm going to go back to our hometown physician who I know will do it. I said oh? Well my three year old neighbor is on antipsychotics for bi-polar disease. So anecdotally, it's still going on. I'd like to see if we have had any effect on those situations and the safety of those situations. So, I was kind of shocked because I thought we'd taken care of that.<br><br>Dr. Mosier: Was the three year old on Medicaid or different?<br><br>Dr. Klingler: I don't know. It would be interesting to see numbers if we've had any effect in promoting safety in that population.<br><br>Dr. Millhuff: I know people are wanting to get out of here. I just want to make one comment on something else, so, the, I, I forwarded to our group some data from the northwest of a consultative service that is lowering prescribing trends with atypical antipsychotics, a study. And, and it raises | |

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| | the question, besides these parameters that we're creating, whether or not our committee has any interest in giving input or guidance to the idea of a consultative service within the State. I know there's a group meeting on high risk kids in the foster care system. That's another network of kids that we're really concerned about. Trying to find better ways to improve prescribing practices. So we're coming up with these guidelines that pretty concrete. But is there anything happening on that front? I know some things have happened before., some different types of programs with the MCOs. But is there anything for a primary care in Great Bend to call in and say 'The mom's asking me about bi-polar, what do I do?'<br><br>Dr. Mosier: Specifically around the foster care kids, there's been significant discussion about doing a pilot for the whole foster care group around how do we, basically improve, in the metrics, we would be looking at improved stability of placement. So we have kids that have gone up to 41 different placements in a year. Reduction in medication use. Especially psychotropics and antipsychotics. We have, in part of that, in looking at it is things like what type of additional services they could receive; how do we stabilize the family; how do we give support to foster care parents; and is there an intermediate. Because right now there's a gap. Because we have, you know, PRTFs, and we home, and we don't really have kind of a step down type of facility. So is there something in between a PRTF? Is there a place where, in transitioning back to the home, where you can work with foster parents and connect the kids and the parents in that transition period in a better way. So there is discussion about that. And we do, that'll be, it's I guess I would say it's in the nascent phases but we definitely want to see what we can do specifically in the foster care system. And then with that kind of model, we can extend that out to other children with behavioral needs in particular. That discussion is going on right now. It's in the nascent stages. But any additional input or practices like this that you've sent would be very welcomed in looking at a design of a pilot geared at that population to really improve the, the, not just the, well the outcomes for these kids, all the way around. Social determinant health outcomes as well as physical health outcomes.<br>Alright, anybody have anything else? Going once. | |
| V. Adjourn | **Committee Discussion:**<br><br>Dr. Moeller: I motion to adjourn.<br><br>Dr. Mosier: Second? | Dr. Mosier adjourned the August 8, 2017 MHMAC meeting at 4:06pm. |

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| | Dr. Millhuff and others: Second.<br><br>Dr. Mosier: Approved. Thank you. We are adjourned. | |
| *Clinical and open public comment requests and written testimony must be submitted one week prior to meeting to Annette.Grant@ks.gov.<br>If providing clinical comment, please indicate which agenda item you are requesting time to comment.<br>Time limits during period of comment will be determined based on number of requests received.<br>The next MHMAC meeting is scheduled for August 8, 2017. | | |